

Extending Assertive Community Treatment to Criminal Justice Settings: Origins, Current Evidence, and Future Directions

Joseph Morrissey, Ph.D.

Piper Meyer, Ph.D.

Gary Cuddeback, Ph.D., M.S.W., M.P.H.

ABSTRACT: This paper presents an overview of Assertive Community Treatment (ACT) as an evidence-based practice in mental health care. We then consider current evidence for FACT (ACT for forensic populations) and FICM (intensive case management for forensic populations) and the ways these models have been extended and adapted to serve mentally ill persons in a variety of criminal justice settings. The available evidence about the effectiveness of these models towards preventing recidivism among criminally-justice involved persons with mental illness is weak. We conclude with several suggestions for how the clinical model of FACT needs to be expanded to incorporate interventions aimed at reducing criminal behavior and recidivism.

J. Morrissey is affiliated with the Cecil G. Sheps Center for Health Services Research and with the Department of Health Policy and Administration, School of Public Health, University of North Carolina, Chapel Hill, USA.

P. Meyer is affiliated with the Cecil G. Sheps Center for Health Services Research and with the Department of Psychology, University of North Carolina, Chapel Hill, USA.

G. Cuddeback is affiliated with the Cecil G. Sheps Center for Health Services Research and with the School of Social Work, University of North Carolina, Chapel Hill, USA.

Address correspondence to Joseph Morrissey, Ph.D., the Cecil G. Sheps Center for Health Services Research and with the Department of Health Policy and Administration, School of Public Health, University of North Carolina, Chapel Hill, USA; e-mail: joe_morrissey@unc.edu.

INTRODUCTION

Assertive Community Treatment (ACT) is a service delivery model in which treatment is provided by a team of professionals with services determined by consumer needs for as long as needed (Phillips et al., 2001). ACT combines treatment, rehabilitation, and support services in a self-contained clinical team made up of a mix of disciplines including psychiatry, nursing, addiction counseling, and vocational rehabilitation (Dixon, 2000; Stein & Santos, 1998). The ACT team operates on a 24-h 7-day a week basis providing services in the community to offer more effective outreach and to help consumers generalize skills to real life settings (Phillips et al., 2001). ACT is intended for consumers who have severe (a subset of serious with a higher degree of disability) mental illness, are functionally impaired, and at high risk of inpatient hospitalization. Often these consumers have high rates of co-occurring substance related disorders, medical co-morbidities including hepatitis and HIV infections, and social risks including poverty, homelessness, and jail detentions.

ORIGIN AND EVOLUTION OF ACT

Assertive Community Treatment emerged in the early 1970s from an innovative program that was designed to prevent the revolving door of repeated hospitalizations for persons with severe mental illness at a state hospital in Madison, Wisconsin (Marx, Test, & Stein, 1973; Stein & Santos, 1998). The core idea was to move active treatment away from the hospital into community settings—in effect, to create a hospital without walls in the community—providing the kind of intensive psychopharmacologic treatment that patients would receive in hospital along with a 24/7 crisis response, assertive engagement, and efforts to help consumers improve their community living skills such as finding a place to live, doing laundry, shopping, cooking, eating in restaurants, budgeting, and using public transportation.

ACT is perhaps the most widely studied psychosocial treatment intervention for people with severe mental illness (see review below). Its adoption rate within the US public mental health system was very gradual throughout the 1980s and well into the 1990s, although it was replicated in other countries including Canada, England, Australia, and Sweden. A major reason for the slow diffusion of ACT in the US was its high per-consumer cost which led to resistance among

administrators of resource-strapped public mental health programs. An underlying issue was which component of government—states or localities—would benefit most from ACT, and which would pay for it. As Weisbrod (1983) made clear in his seminal cost-effectiveness study of the original ACT experiment, the prime beneficiary is the state which saves the costs of caring for people who otherwise would be frequently re-admitted to the high cost acute care units of state psychiatric hospitals. The payers, however, would be the Federal government (through SSI, Medicaid, housing vouchers, and other welfare costs) and the county or local program that would face the direct cost of staffing the ACT team, but also spill-over costs associated with housing, local welfare, and other public services for consumers who, had they been hospitalized in a state facility rather than assigned to ACT, would be a 100% cost to the state. In effect, Weisbrod's analysis demonstrated that adoption of ACT in other communities would likely result in a cost-shift from the state to the county or local program and Federal government.

The adoption rate began to accelerate in the 1990s. Many factors contributed to this growth including the endorsement of the National Alliance on Mental Illness (NAMI) which embraced ACT (Allness & Knoedler, 1999), made it a national priority, and created a Technical Assistance Center to coordinate efforts across states and to lobby for Medicaid reimbursement (Torrey et al., 2001). In the past several years, ACT has also been championed by the evidence-based practices movement. It has become part of most best practice standards including the Schizophrenia Patient Outcomes Research Team recommendations (Lehman et al., 1998) and one of six toolkits implemented as part of the National Evidence-Based Practices Project (Mueser, Torrey, Lynde, Singer, & Drake, 2003). The prospect of Medicaid reimbursement has altered the reluctance of many localities to buy into ACT. Reimbursements from Medicaid shift a large portion of ACT costs from the county to the Federal government. Now, over 35 states have implemented ACT to various degrees and a few including New York and Indiana are rapidly deploying it on a state-wide basis via Medicaid reimbursement.

In reality, the concept of ACT diffused much more rapidly than its practice. Programs cropped up all over the country claiming to be "just like ACT", but failed to faithfully replicate its essential structure and staffing. Consequently, fidelity ratings to the ACT model became a major focus and standard (Teague, Bond, & Drake, 1998). Fidelity scales have been shown to differentiate true ACT programs from

various types of case management, and higher fidelity scores have usually been associated with better outcomes (McGrew, Bond, Dietzen, & Salyers, 1994; Teague et al., 1998), but not always (Bond & Salyers, 2004). However, no one has conducted a dismantling study to determine precisely which programmatic elements of ACT are linked to positive program outcomes. The research to date on ACT has shown only that the combination of all the critical elements leads to more positive outcomes (LewinGroup, 2000). The implication is that departures from full fidelity are likely to produce diminished outcomes or no effects at all.

EVIDENCE-BASE FOR ACT

The effectiveness of ACT has been well established with over 40 controlled studies in the US and abroad (Bond, Drake, Mueser, & Latimer, 2001; Marshall, Gray, Lockwood, & Green, 1998; Ziguras & Stuart, 2000). In one review of early trials (Bond et al., 2001—See Table 1), ACT was found to be most effective in reducing the use and number of days in the hospital, moderately effective in improving symptoms, but *not* consistently effective in reducing arrests/jail time or improving social adjustment, substance abuse, and quality of life (also see Burns & Santos, 1995; Dixon, 2000; Marshall & Lockwood, 2004; Ziguras &

TABLE 1

Significant Outcomes for Assertive Community Treatment in 25 Randomized Controlled Trials (Adapted from Bond et al., 2001)

Outcomes	Effectiveness of ACT Compared with Control Conditions (Number of Trials (%))		
	Better	No difference	Worse
Psychiatric hospital use	17 (74%)	6 (26%)	0
Symptoms	7 (44%)	9 (56%)	0
Quality of life	7 (58%)	5 (42%)	0
Social adjustment	3 (23%)	10 (77%)	0
Substance use	2 (33%)	4 (67%)	0
Arrests/jail time	2 (20%)	7 (70%)	1 (10%)

Stuart, 2000). When tested against other forms of case management, ACT teams have proven to be more effective *only* in reducing psychiatric hospitalizations and improving housing stability (Bond et al., 2001; Burns & Santos, 1995; LewinGroup, 2000; Mueser, Bond, Drake, & Resnick, 1998; Ziguras & Stuart, 2000).

The evidence for the lack of effectiveness in reducing substance abuse behaviors only began to turn around when the original ACT model was adapted to focus on these behaviors (Drake, Mueser, Brunette, & McHugo, 2004). Beginning in the late 1980s and 1990s, co-occurring substance abuse disorders were recognized as a pervasive and growing problem for persons with severe mental illness. As ACT teams focused on these needs, began incorporating addiction counselors and treatments for substance abuse into their routine care, and transitioned into “integrated dual diagnosis treatment teams” (IDDT) the research began to show positive effects on substance abuse outcomes (compare Morse et al., 1992 and Mercer McFadden, Drake, Brown, & Fox, 1997 with Drake et al., 1998). Essentially the same experience was replicated for ACT teams in the area of work and supported-employment programs (Gold et al., 2006; Macias et al., 2006; McGrew & Bond, 1995; Rogers, Drake, Becker, Bond, & Mueser, 2003).

The implication for extending ACT to criminal justice involved populations that can be derived from these experiences is that ACT alone is not enough to keep people with severe mental illness out of jail—something else needs to be added to the existing mix of ACT services. Evidence to support this conclusion comes from a recent clinical trial reported by Calsyn and colleagues (2005). In this study, 144 homeless subjects with dual severe mental illness and substance abuse disorders were randomized to IDDT, ACT, and usual care services and followed for two years. (The IDDT condition was never fully implemented so in the analyses data from the IDDT and ACT arms were combined into a single ACT team vs. usual care comparison.) During the follow-up period, 52% of the sample was arrested and 26% was incarcerated in jail. However, receipt of ACT was not a significant predictor of any of the six criminal justice indicators that were used as study outcomes: substance abuse offenses, minor offenses, major offenses, arrests, incarcerations, or court summons. The authors conclude that the widely established benefits of ACT for decreased hospitalization and improved housing do not carry over to criminal behavior; rather, extra interventions that specifically target reduction of criminal behavior are needed.

Can ACT be adapted to prevent recidivism among persons with severe mental illness who are involved with the criminal justice system? By mimicking IDDT teams, for example, would arrests and jail detentions be reduced by modified ACT teams that enroll only persons with severe mental illness who are involved with the criminal justice system, incorporate or develop new specialists within the team with criminal justice system savvy, and foster close working relationships with police and jail authorities? This question is addressed in the following section.

FORENSIC ACT (FACT)

Jails have clearly supplanted state hospitals as the main revolving door for the most disabled people in the public mental health system. (Additional thousands of persons with mental illness are serving sentences in state prisons, see Ditton, 1999.) The growing recognition of this situation has led a number of programs around the country to develop specialized ACT teams that shift the focus from just preventing hospitalization to preventing jail detention and recidivism for persons with severe mental illness who are involved in the justice system. The name “forensic ACT” or FACT is the emerging designation for these hybrid teams.

A cursory look at criminal justice statistics demonstrates the need for an intensive ACT-like intervention for mentally ill offenders and jail detainees. There are now over 12.5 million detentions each year in county jails in the US (Karberg, 2004). Based on current best screening estimates (Teplin, 1990; Teplin, Abram, & McClelland, 1996) about 8% or 1 million of these detentions involve persons with severe mental illness. The magnitude of these numbers is staggering in their own right, but they take on added weight when one realizes the startling truth that, as a group, *persons with severe mental illness are jailed more often than hospitalized*. In 1997, there were 126,663 adult admissions with severe mental illness to state and county mental hospitals, and overall, about 645,237 admissions with severe mental illness to any type of psychiatric hospital (Milazzo-Sayre et al., 2001) whereas they were at least one million detentions of persons with severe mental illness in jails. This means that people with severe mental illness were jailed 1.5 times more often than they were admitted to a psychiatric hospital and 8 times more often than admitted to a state mental hospital. Stated

otherwise, the relative annual risk of a person with severe mental illness being detained in jail is 150% greater than admission to any type of hospital for inpatient psychiatric care, and 800% greater than admission to a state psychiatric hospital! (The relative rarity of state hospital admissions is due to their decreased bed capacity and the legal restrictions in most states surrounding who can be admitted.)

Currently, there is a lot of exploration going on with FACT interventions and there is little standardization of program practices and staffing. As with ACT in the larger public mental health system, the concept of FACT has disseminated more rapidly than the actual practice of using a high-fidelity ACT team with criminal justice populations. FACT teams often operate from an "ACT-lite" perspective that strips away some of the high-fidelity elements (such as 24/7 availability, daily team meetings, employment specialists) and adds new elements not found in typical ACT teams (such as a probation, parole, or police officer).

Lamberti, Weisman, and Faden (2004) suggest the following four core elements that distinguish FACT from ACT: the goal of preventing arrest and incarceration, requiring that all consumers admitted to the team have criminal justice histories, accepting the majority of referrals from criminal justice agencies, and the development and incorporation of a supervised residential treatment component for high-risk consumers, particularly those with co-occurring substance use disorders.

FACT Variations

The criminal charges of consumers accepted into these programs vary widely, from nonviolent misdemeanors only to a mix of felonies and misdemeanors including violent offenses (Cuddeback et al., 2006). These programs have been situated at various stages of criminal justice processing including diversion from jail prior to adjudication, mental health courts for conditional release from jail and on-going treatment monitoring, and jail re-entry after serving a sentence. FACT teams are also used with special populations such as NGRI (not guilty by reason of insanity) cases who are acquitted of their crime, treated for a number of months or years in a state psychiatric hospital forensics unit, and released to the community under court supervision. They are also being used as prison re-entry programs for offenders with severe mental illness who have served multi-year sentences in state prisons and are released or paroled to community settings (Council of State Governments, 2005).

Auspice may make a difference here as some of these teams developed from criminal justice initiatives whereas others are mental health system-based. Teams sponsored by criminal justice authorities are usually distinguished in part by a staffing pattern that includes one or more full-time probation, parole, or law enforcement personnel. Budgetary issues, collaboration challenges, cost shifts between criminal justice and mental health agencies, and trade-offs between who benefits—who pays all resurface here (Chandler, Peters, Field, & Juliano-Bult, 2004).

The same asymmetry that deterred counties from adopting ACT can re-emerge here as well, but the cost shift now juxtaposes county mental health with county or state correctional authorities. County jails and state prisons are potentially the prime beneficiaries of FACT in terms of cost savings from reductions in census, special services, and dedicated staffing. For example, when correctional grant funding for the MIOCRG-II initiative in California ended in 2004 (see below), most counties did not see a benefit in continuing to fund FACT teams at the same level through their county mental health budgets. As a result, many programs were either de-intensified or discontinued.

FACT Evidence-Base

No one has yet published findings from a randomized study of a dedicated FACT team that serves a full caseload of mentally ill consumers who have forensic involvements. The published evidence on FACT is limited to two recent studies (McCoy, Roberts, Hanrahan, Clay, & Luchins, 2004; Weisman, Lamberti, & Price, 2004).

In a single group pre–post study (no control group), consumers who completed one year of Project Link in Rochester, NY (Lamberti et al., 2001) had significant reductions in jail days, arrests, hospital days, and hospitalizations. A preliminary pre–post cost analysis also found that Project Link reduced the average yearly service cost per client (Weisman et al., 2004). In two treatment group pre–post studies conducted at the Thresholds State/County Collaborative Jail Linkage Project in Chicago, consumers had a decrease in days in jail and days in the hospital and reduced jail and hospital costs in the year following program entry (McCoy et al., 2004; Thresholds State/County Collaborative Jail Linkage Project Chicago, 2001). Neither project has reported on any other mental health or quality of life outcomes.

Several of the Mentally Ill Offender Crime Reduction Grant (MIOCRG-II) sites in California started out with the goal of experimentally

evaluating FACT interventions (California Board of Corrections, June, 2004), but with state budget reductions and early defunding of the initiative, the intensity of the county programs was often diluted and only a few retained an acceptable level of fidelity to the ACT model as measured by the Dartmouth Assertive Community Treatment Scale (Teague et al., 1998). So in the end, the interventions in many counties turned out to be more like FICMs (see below) than true FACTs.

A statewide evaluation conducted by the California Board of Corrections aggregated data across 20 of the original 30 county programs for a pooled analysis of outcomes. To date, no published reports have come from this evaluation. A summary report (California Board of Corrections, 2005) indicates that small differences (3% to 4%) favoring the intervention groups were found on a series of criminal justice indicators (jail bookings, convictions, and jail time) along with some evidence of improved quality of life (reductions in drug-alcohol problems and improved functioning). In addition, those programs that had medium to high ACT fidelity were reported to have better criminal justice and quality of life outcomes, but no effect sizes or other supporting data were provided nor were statistical controls used to adjust for potential confounding variables. Fuller reporting and publication of these findings would bolster the current evidence base for FACT programs.

FORENSIC INTENSIVE CASE MANAGEMENT (FICM)

Due to concerns about the cost of ACT, many jurisdictions have turned to intensive case management approaches to serve mentally ill offenders. These forensic intensive case management (FICM) models have some distinct differences from ACT and require less funding than a full-fidelity ACT team. ACT requires a multidisciplinary team with shared caseloads that meets frequently and uses a comprehensive treatment and rehabilitation model where the psychiatrist and nurse have a critical role. Intensive case management often mirrors ACT with regard to assertive, in-vivo, and time-unlimited services, but it uses case managers with individual caseloads, has no self-contained team, lacks 24/7 capacity, and brokers access to psychiatric treatment rather than providing it directly (Schaeuble, McGrew, Bond, & Epstein, 2002). In developing true costs for FICM, then, care must be taken to include

the cost of treatments and other services to which FICM is linked. Since FACT is a more self-contained treatment team, many of these costs are already built into its cost profile.

FICM Evidence-Base

Current evidence indicates that brokered case management is largely ineffective (Marshall et al., 1998) whereas strengths case management appears to be effective in a small number of trials (Rapp & Goscha, 2004). The evidence-base for FICM effectiveness comes from several published studies (Cosden, Ellens, Schnell, Yamini Diouf, & Wolfe, 2003; Godley et al., 2000; Solomon & Draine, 1995; Wilson, Tien, & Eaves, 1995) and from the nine-site SAMHSA Jail Diversion Demonstration where sites used FICM in a service linkage and transition model (Broner, Lattimore, Cowell, & Schlenger, 2004; Steadman et al., 1999; Steadman & Naples, 2005). There is another SAMHSA jail diversion evaluation now underway as part of a Targeted-Capacity Expansion initiative that involves more than 30 sites that use a number of variations of the FICM model (TAPA Center for Jail Diversion, 2004). Findings will be available in the next year.

The current evidence on FICM effectiveness can be summarized with findings from the SAMHSA jail diversion study (Broner et al., 2004; Steadman & Naples, 2005). This study involved a non-random comparison group design to evaluate the effectiveness of jail diversion. Detainees at several diverse sites around the country were diverted to FICM services in the community and their experiences over the next two years were then compared with those of usual care comparison groups. Diverted individuals reported more days in the community, more service use, and fewer jail days than did the non-diverted comparison groups, but there were no consistent differences on symptoms or quality of life. In other words, diversion to FICM improved jail incarceration outcomes, but it had little or no effect on public mental health outcomes. (One exception is Godley and colleagues (2000) who report both symptom improvements and jail time reductions.)

Steadman and Naples (2005) argue that the failure to find any mental health effects in the SAMHSA jail diversion study was due to the nature of the community-based treatment services to which diverted individuals were referred. These services were routine, everyday community mental health services; none was an evidence-based, intensive treatment service such as ACT or IDDT. As a result, the diverted subjects (most of whom had co-occurring mental health and

substance abuse disorders) did not show any consistent symptom or functioning differences at follow-up in comparison to the not-diverted group. Although FICM was employed by most sites, it was used on a short-term basis preliminary to transitioning consumers to available community mental health providers.

Two random clinical trials have been reported here as well, one from Philadelphia (Solomon & Draine, 1995) and one from a California MI-OCRG site (Cosden et al., 2003). The Philadelphia study compared FICM with FACT and with usual care services finding no significant differences in social or clinical outcomes between the three groups after one year of services. However, there was a higher re-arrest rate for subjects assigned to the FACT condition (attributed to having probation officers on the team). The California study compared a combined mental health court and FICM model (that also had probation officers as team members) with usual care; at 12-months, both groups exhibited improvements in life satisfaction, psychological distress, independent functioning, and drug problems. No differences were found for time in jail or number of arrests, but in a finding that mirrors the Philadelphia study, consumers in the intervention arm were more likely to be booked and not convicted, and to have been arrested for probation violations, whereas members of the usual care group were more likely to have been convicted of a new crime.

FURTHER MODEL DEVELOPMENT

Currently, the supporting evidence about the effectiveness of FACT in reducing arrests and keeping people out of jail is weak. Moreover, there is no compelling evidence that FICM can produce positive results at a reduced cost. There is a great need for carefully designed, randomized studies of FACT interventions to assess their effectiveness and costs in achieving both public mental health and criminal justice outcomes as well as their potential at scale to substantially reduce the numbers of persons with severe mental illness who are detained in jail.

However, a big obstacle standing in the way of such research is the absence of a clearly specified clinical model for FACT, especially as regards criminal behavior. By itself, as documented above, high-fidelity ACT is not enough to prevent arrests and to keep people with severe mental illness out of jail; its FACT adaptations so far have produced inconsistent results. Under these circumstances, investing scarce

resources in randomized trials of one or another of the current FACT configurations is not a wise investment. Such efforts might even lead to set backs. A few premature trials with negative results could easily discourage funding for further research and problem-solving efforts in this area.

The wiser course is to invest more effort in specifying a model within FACT for intervening on the criminal behavior and criminal tendencies of the subset of people with severe mental illness who are in repeated contact with police and jails. Is there anything that will lower the criminal recidivism rates of these individuals? While there is little research on mentally ill offenders in this regard, some insights and leads can be gleaned from the adult corrections literature. We are guided here by a recent systematic review of crime reduction studies conducted by the Washington State Institute for Public Policy (WSIPP) (Aos, Miller, & Drake, 2006). The review included over 300 comparison group studies published in English language journals since 1970. The authors found several successful interventions with small positive effect sizes (mostly in the .05–.11 range) and a much larger number that were not successful at all. Three of the successful interventions that are particularly salient for a severely mentally ill population—specialized cognitive behavioral therapy, modified therapeutic communities, and drug courts—are highlighted below.

The WSIPP report identifies 25 rigorous studies of cognitive behavioral therapy (CBT) with the general offender population. This type of group therapy addresses the irrational thoughts and beliefs that lead to anti-social behavior. Many of the offenses that get people with severe mental illness into jail are minor; associated with public disturbances, petty theft, or violations of civility statutes. Others are felonies, often associated with illegal drug use (Fisher et al., 2006). Both types of offenses are common for homeless individuals on the streets or those marginally housed in shelters and other temporary residences. In many respects, these street behaviors may result from poor decision-making in difficult circumstances as opposed to being the product of a deep seated “criminal mind.”

Two types of manualized CBT interventions—Moral Reconation Therapy (Little & Robinson, 1998) and Reasoning and Rehabilitation (Ross, Fabiano, & Evans, 1988; Ross & Ross, 1995)—have been shown to be effective in reducing criminal behavior, with an average effect size of .08 (WSIPP, 2006; also see Allen, MacKenzie, & Hickman, 2001). Both are designed to help offenders correct their thinking and provide

opportunities to model and practice problem-solving and pro-social skills. Given the success of CBT with severely mentally ill individuals, these criminal behavior-oriented interventions should be tried with FACT to determine whether a FACT plus a criminal behavior-oriented CBT model can improve mental health and criminal justice outcomes.

Therapeutic communities (TCs) have had a long history in mental health and substance abuse treatment for offender populations (Wexler, 1995; De Leon, 2000). These residential programs offer intensive interventions and support that may not be present in outpatient settings. TCs in jails and prisons usually contain separate residential units for the offenders and follow group-run principles of organizing and operating the drug-free unit. The WSIPP report found that the average in-prison TC reduces recidivism by 5.3% with an additional boost to 6.9% with a community aftercare component (Aos et al., 2006). However, one limitation to the widespread use of TCs in jails is the relatively short lengths of stay in most jails in contrast to the long stays in prison.

Two trials of modified TCs for MICA (mentally ill/chemical abusing) offenders have been reported (Sacks, Sacks, McKendrick, Banks, & Stommel, 2004; Van Stelle & Moberg, 2004) and, despite the use of small samples, both show promise of reducing recidivism rates. This approach responds to the need for community among mentally ill offenders, and attempts to use peer-support to model and re-enforce pro-social behavior. As with the CBT approaches mentioned above, integrating modified TCs with FACT programs in community settings seems to be a promising idea that warrants further research.

Finally, there is strong evidence that adult drug courts are effective in reducing criminal recidivism. The WSIPP review found 56 evaluations of these types of programs; on average, a statistically significant 10.7% reduction was found in the recidivism rates of program participants relative to treatment-as-usual comparison subjects (Aos et al., 2006). There has been a rapid proliferation of mental health courts throughout the country in the past several years that are loosely modeled on the drug court experience (Redlich, Steadman, Monahan, Robbins, & Petrila, 2006). But insufficient outcome research has been conducted to date to know if these drug-court benefits generalize to mental health courts.

The combination of extra leverage via court sanctions and the experience of having consumers appear before a robed judge for regular monitoring may provide extra leverage for FACT teams to engage

recalcitrant consumers (Griffin, Steadman, & Petrila, 2002; Monahan et al., 2005). Early mental health court studies suggest increased access to services, but no intervention effects on quality of care or symptom reduction (Boothroyd, Mercado, Poythress, Christy, & Petrila, 2005; Steadman et al., 2005). These are mostly site specific studies. The first multi-site study is currently being conducted under the auspices of the MacArthur Foundation's Mandated Treatment Research Network (2006).

CONCLUSION

Over the last decade, ACT has been applied to a number of new populations based on the naïve assumption that ACT is appropriate for any difficult consumer. The IDDT experience suggests that the basic ACT model needs to be re-invented to fit new populations and new needs. Today, the interface between the mental health and criminal justice systems is the new frontier for innovative services and research in the community mental health field. The challenges of diverting hundreds of thousands of mentally ill persons from jail rival those faced by Marx et al. (1973) who devised ACT some thirty-five years ago as an alternative to the state mental hospital for people with severe mental illness.

While only a minority of the population of persons with severe mental illness is involved with the criminal justice system, those who are repeatedly involved are a special needs group that has yet to benefit either from the original wave of ACT teams or from the current evidence-based practices movement. It now seems clear that, to be successful, jail diversion for these individuals requires something more than current versions of ACT, FACT, or FICM.

A clinical model for FACT must be developed that incorporates explicit modules that focus on reduction of criminal behavior and recidivism. A number of promising candidate interventions are available, but they have yet to be fully integrated with FACT services in a coherent model. The development and test of these hybrid models should be a high priority for the mental health services research field. Growing the evidence-base here can go a long way toward enhancing recovery and successful community living for many thousands of persons with severe mental illness who now cycle in and out of the criminal justice system.

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